

PROVIDER MANUAL

AMBULATORY BEHAVIORAL HEALTH CARE
FOR
ADULTS



Published By:

North Dakota Department of Human Services
Medical Services Division
600 East Boulevard, Dept. 325
Bismarck, ND 58505-0261

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DEFINITION OF TERMS

Ambulatory Behavioral Healthcare (ABH): A time limited, ambulatory, active treatment program pursuing the goal of stabilization with the intention of averting inpatient hospitalization or reducing the length of a hospital stay. ABH services are designed to serve individuals with significant impairment resulting from a psychiatric, emotional, behavioral or addictive disorder.

Authorization: Determination indicating that utilization review resulted in approval for Medicaid services and an authorization is issued.

Appeal: A request from a recipient or his authorized representative to disagree with a denial for services and the opportunity to present his case to a reviewing authority.

Continued Stay Review: A review of currently delivered treatment to determine medical necessity of a continued level of care.

Deferral: Clinical reviewer determines that medical necessity is not met based on present information and the case is deferred to the division's physician consultant for review and final determination.

Denial: Request for authorization does not meet the appropriate Medicaid medical necessity criteria for the services requested. Authorization is denied.

Disciplines: Disciplines are defined as social workers (any level), recreational therapists, occupational therapists (any level), nursing (any level), licensed practicing clinical counselors, and licensed addiction counselors (any level).

Division: The North Dakota Department of Human Services Medical Services Division.

Desk Reconsideration: A process to accommodate a facility's disagreement of a denial.

Hours of Operation (the Division): Monday through Friday, 8:00 a.m. to 5:00 p.m., Central Standard Time, excluding State holidays.

Partial Approval: An adverse payment determination indicating that only a portion of a stay is authorized as medically necessary. The Desk Reconsideration/Appeal process applies to the portion of the stay that has been denied.

Pending Authorization: Indication that the division's clinical reviewer has requested additional information from the provider.

Relevant Parties: Recipients, parents or legal guardians of recipients, and requesting providers.

Technical Denial: Authorization was not administered on medical necessity criteria as a result of provider non-compliance with Medicaid protocol (i.e., timeframes, incomplete documentation). This level of denials is "provider responsibility."

OVERVIEW

Purpose of the Program

The federal government, through the Center for Medicare and Medicaid Services requires that all agencies serving a Medicaid population and receiving Medicaid funds have a utilization control program in place to monitor each recipient's need for services, before payment for the intended services is authorized. The purpose of the program is to ensure that the intended services are appropriate to each individual's symptoms according to Medicaid established protocols and medical criteria, and are neither over utilized, nor under utilized. The requirement for this type of review became statutory in 1972 for Medicaid and Medicare programs.

Purpose of this Manual

The intent of this *Provider Manual for Ambulatory Behavioral Healthcare (ABH)* is to give enrolled providers detailed instructions for initiating the review processes. The manual provides specific instruction for each type of service requested, including Admission Review; Continued Stay Review; and Retrospective Reviews of medical necessity and treatment efficacy of services delivered to North Dakota Medicaid recipients and applicants. This *Provider Manual for Ambulatory Behavioral Healthcare* is intended to be an educative and informative training guide for providers.

The manual informs providers of established protocols and medical necessity criteria that must be met in order for the division to recommend approval of payment for proposed treatment.

Hours of Operation / Operating Numbers

The division's standard hours of operation are Monday through Friday, 8:00 a.m. to 5:00 p.m. Central Time, excluding State Holidays. The division is available by telephone, facsimile, U.S. mail or e-mail. Contact information is:

Telephone: (701) 328-4027 or 1-800-755-2604
Fax: (701) 328-1544

U.S. Mail: Medical Services
600 E. Boulevard Ave, Dept. 325
Bismarck, ND 58505

e-mail: dhsmed@state.nd.us

Review Process

The review process is a fax or mail based process. The formal review process, applied medical necessity criteria, determination, approved time frames, and notification process varies for each review type. Therefore, well-detailed subsections of this manual are devoted to each review type and applicable review process.

AMBULATORY BEHAVIORAL HEALTHCARE

Definition

The North Dakota Department of Human Services, Medicaid Division, hereafter referred to as the division, defines Ambulatory Behavioral Healthcare (ABH) as a time limited, ambulatory, active treatment program pursuing the goal of stabilization with the intention of averting inpatient hospitalization or reducing the length of a hospital stay. ABH services are designed to serve individuals with significant impairment resulting from a psychiatric, emotional, behavioral and/or addictive disorder. Treatment programs employ an integrated, comprehensive and complimentary schedule of recognized treatment approaches and embraces day, evening, night and weekend treatment programs. Support and supervision must be sufficient to maintain the person's safety outside the hospital. The care delivered must be ordered and supervised by a physician or psychiatrist. Treatment is pro-active, intensive, and provided in a supervised environment by a multi-disciplinary team of qualified professionals including, but not limited to, psychologists, social workers, psychiatric nurses, occupational therapists, recreational therapists, educators and mental health and substance abuse counselors. Treatment, including but not limited to psycho-educational, psychotherapy, activity therapy and occupational therapy, is focused on the following:

- Reducing the risk of behaviors destructive to self or to other, including impulsive behaviors such as mutilation
- Reducing symptoms in reference to the DSM IV Diagnosis
- Reducing the probability of behaviors likely to lead to the need for a more restrictive level of care
- Reducing medical factors that are associated with a mental disorder and place the patient at significant risk.

Admission Reviews

All admissions to ABH require prior authorization and must meet medical necessity as defined in the *Criteria for ABH Admissions* (refer to page 15). This process applies to all Medicaid eligible recipients, recipients who apply for Medicaid prior to admission (pending eligibility), or recipients who apply for Medicaid during the receipt of services.

- **NOTE TO PROVIDERS:** Retrospective reviews will be conducted on recipients who apply for Medicaid after receipt of ABH services

Continued Stay Reviews

All ABH services that extend beyond the initial authorization date must be authorized through a Continued Stay Review. Authorization for continued stay is contingent upon meeting medical necessity criteria as defined in *the Criteria for ABH Continued Stay Review* (page 18).

Discharge Procedure

Upon recipient discharge from ABH service for which prior authorization or continued stay reviews have been performed, the provider must submit the discharge summary. This must be submitted to the division within fifteen (15) business days after discharge. Include in this report the total number of days attended at each level.

PRIOR AUTHORIZATION ADMISSION REVIEW PROCEDURE

Definition

An ABH admission is a scheduled admission that is subject to the choice or discretion of the recipient or the physician advisor regarding medical services and/or procedures that are medically necessary and advantageous to the recipient, but not necessary to prevent death or disability. Prior authorization is required for all admissions to an ABH program.

Prior Authorization Admission Review Procedure for Medicaid Recipients

The following procedures will be followed for prior authorization admission reviews:

1. The provider is responsible for verifying the recipient's Medicaid eligibility or Medicaid application.
2. The provider is responsible for notifying the division within three (3) business days prior to or on admission. Failure to do so will result in a technical denial of admission approval.
3. The provider must submit an *ABH Prior Authorization/Continued Stay* form by fax that includes demographic and clinical information at the time of the initial notification to the division. Refer to Appendix A for an example of the *ABH Prior Authorization/Continued Stay* form and instructions for completion. This information must be sufficient for the clinical reviewer to make a determination regarding medical necessity and must include:
 - Demographic information
 - Recipient's Medicaid ID number
 - Recipient's Social Security Number (SSN)
 - Recipient's name, date of birth, sex
 - Recipient's address, county of eligibility, telephone number
 - Responsible party name, address, phone number
 - Provider name, planned date of admission
 - Clinical information
 - Prior inpatient treatment
 - Prior outpatient treatment/alternative treatment
 - Estimated length of stay
 - Initial treatment plan
 - DSM IV diagnosis on Axis I through V
 - Medication history
 - Current behavior/symptoms
 - Appropriate medical, social, and family histories
 - Proposed discharge plan

4. The recipient's treatment must be documented to meet all of the following criteria as stated in Admission Criteria (page 16).
5. Upon fax/mail receipt of the above documentation, the division's clinical reviewer will complete the review process and notify the provider of the determination by fax, telephone, or e-mail within two (2) business days from receipt of the review request.

The following determinations apply to prior authorization admission reviews:

- **Approval:** If medical necessity is met, the clinical reviewer will authorize the admission and an ABH stay up to 10 calendar days.
- **Pending:** If the clinical reviewer determines that additional information is needed to complete the review, the provider must submit the requested information within two (2) business days of the request for additional information.
 - If additional information is received within two (2) business days of the request and medical necessity is met, the authorization review will be completed and the provider notified by fax/telephone of the review determination within two (2) business days from receipt of the additional information.
 - If additional information is not received from the provider within two (2) business days of the request, a technical denial will be issued.
- **Deferral:** If medical necessity is not met, the case is deferred to the division's physician consultant.
 - The physician will review the case and make a determination within three (3) business days of deferral or receipt of additional information.
 - The division will notify the provider by fax/telephone of the review determination within two (2) business days of the determination.
- **Denial:** Upon receipt of the needed information and discussion held with a physician, a denial will be issued within two (2) business days; the recipient will be notified of the denial and appeal rights.

**Admission Review Procedure for Recipients Who Apply for Medicaid During
Receipt of ABH Services**

Definition

Admission reviews are conducted for individuals who apply for Medicaid after admission but prior to discharge from ABH.

Admission Review Procedure

The following procedure will be followed for admission reviews on recipients applying for Medicaid during receipt of services:

1. The provider is responsible for verifying the recipient's Medicaid eligibility or Medicaid application.
2. The provider is responsible for notifying the division by fax/mail within two (2) business days of notification regarding the recipient's application for Medicaid.
3. The provider must submit an *ABH Prior Authorization/Continued Stay* form by fax/mail that includes demographic and clinical information at the time of initial notification to the division. Refer to Appendix A for an example of the *ABH Prior Authorization/ Continued Stay* form and instructions on form completion. This information must be sufficient for the clinical reviewer to make a determination regarding medical necessity and must include:
 - Demographic information
 - Recipient's Medicaid ID number (MID)
 - Recipient's social security number (SSN)
 - Recipient's name, date of birth, sex
 - Recipient's address, county of eligibility, telephone number
 - Responsible party's name, address, phone number
 - Provider's name, date of admission
 - Clinical information
 - Prior inpatient treatment
 - Prior outpatient treatment/alternative treatment
 - Initial treatment plan
 - Estimated length of stay
 - Admitting diagnoses/DSM-IV diagnosis on Axis I through V
 - Medical history
 - Precautions
 - Current symptoms requiring ABH
 - Chronic behavior/symptoms
 - Appropriate medical, social, and family histories
 - Discharge plan

4. Upon fax/mail receipt of the above documentation, the division's clinical reviewer will complete the review process and notify the provider of the determination by fax/telephone within two (2) business days from receipt of the review request.

The following determinations apply to ABH admission reviews:

- **Approval:** If medical necessity is met, the clinical reviewer will authorize the admission and ABH stay of up to 10 calendar days.
- **Pending:** If the clinical reviewer determines that additional information is needed to complete the review, the division will contact the provider and request additional medical record information. The provider must submit the requested information within two (2) business days of the request for additional information.
 - If additional information is received within two (2) business days of the request and medical necessity is met, the initial review will be completed and the provider notified by fax/telephone within two (2) business days from receipt of additional information.
 - If additional information is not received from the provider within two (2) business days of the request, a technical denial will be issued.
- **Deferral:** If medical necessity is not met, the case is deferred to the division's physician consultant.
 - The physician will review the case and make a determination within three (3) business days of deferral or receipt of additional information.
 - The division will notify the provider by fax/telephone of the review determination within two (2) business days of the determination.
- **Partial Approval:** The Division will issue a partial approval determination when only a portion of a stay meets Medicaid medical necessity criteria.
- **Denial:** The Division will issue a denial if the request for authorization does not meet the Medicaid medical necessity criteria for the services requested.

**Admission Review Procedure for Recipients Who
Apply for Medicaid after Receipt of Ambulatory Behavioral Health Care**

Definition

An admission review is conducted retrospectively for recipients who apply for Medicaid after receipt of ABH.

Admission Review Process-Retrospective

1. For recipients who apply for Medicaid after receipt of ABH, the provider is responsible for contacting the division by fax/mail within two (2) business days of notification (to clinical personnel only) regarding the individual's application for Medicaid.
2. The provider must submit the recipient's entire medical record and a *Retrospective Review Request* form at the time of initial notification to the division. Refer to Appendix B for an example of the *Retrospective Review Request* form. The medical record information must be sufficient for the clinical reviewer to make a determination regarding medical necessity.
3. Upon receipt of the medical record, the division's clinical reviewer will complete the review process and notify the provider of the determination by fax/mail within three (3) business days from receipt of the medical record.

The following determinations apply to ABH retrospective reviews:

- **Approval:** If medical necessity is met, the clinical reviewer will authorize the ABH admission and length of stay.
- **Pending:** If the clinical reviewer determines that additional information is needed to complete the review, the provider must submit the requested information within two (2) business days of the request for additional information.
 - If additional information is received within two (2) business days of the request and medical necessity is met, the authorization review will be completed and the provider notified by fax/telephone of the review determination within two (2) business days from receipt of additional information.
 - If additional information is not received from the provider within two (2) business days of the request, a technical denial will be issued.

- **Deferral:** If medical necessity is not met for the entire length of stay, then the case is deferred to the division's physician consultant for review and determination.
 - The reviewing physician will determine whether the admission met standards for approval of the entire stay, approval of a partial stay, or a denial for the entire stay.
 - The physician will review the case and make a determination within three (3) business days of deferral.
 - The division will notify the provider by fax/telephone of the review determination within two (2) business days of the determination.
- **Partial Approval:** The Division issues a partial approval determination when only a portion of a stay meets Medicaid medical necessity criteria.
- **Denial:** The Division will issue a denial if the request for authorization does not meet the Medicaid medical necessity criteria for the services requested.

CONTINUED STAY REVIEW PROCEDURE

Definition

A continued stay review is a review of currently delivered treatment to determine ongoing medical necessity for continued ABH. Continued stay reviews are performed subsequent to all authorized admissions for ABH that extend beyond the number of days initially authorized.

Requests for continued stay authorization are based on updated treatment plans, progress notes, and recommendations of the recipient's treatment team. Continued stay requests require prior authorization and must meet the medical necessity criteria as defined in the *Continued Stay Criteria* (pg. 18).

Length of Stay

The division will conduct continued stay reviews for medically necessary stays for ABH that extend beyond the number of days initially authorized. Continued stay reviews apply to Medicaid recipients/applicants who are eligible on admission and for individuals who apply for Medicaid after admission. Each continued stay review may permit authorization of an additional stay of up to 10 calendar days, not to exceed identified limits when medical necessity is determined (see addendum C). *Medicaid payment will not be made for unauthorized days*

Continued Stay Review Procedure

1. For recipients who are Medicaid eligible on date of admission or recipients who apply for eligibility during receipt of ABH, the provider is responsible for contacting the division by fax/mail within two (2) business days prior to the termination of the current authorization period.
2. The provider must submit an *ABH Prior Authorization/Continued Stay* form by fax that includes demographic and clinical information. Refer to Appendix A for an example of the *Continued Stay Request* form. This information must be sufficient for the clinical reviewer to make a determination regarding medical necessity and must include:
 - Changes to current DSM-IV diagnosis on Axis I through V
 - Justification for continued services at this level of care
 - Assessment of treatment progress related to admitting symptoms and identified treatment goals
 - Current list of medications or rationale for medication changes, if applicable
 - Projected discharge date and clinically appropriate discharge plan, citing evidence of progress toward completion of that plan
3. Upon fax receipt of the above information, the division's clinical reviewer will complete the continued stay review process and notify the provider of the determination by fax/mail within two (2) business days from the receipt of the review request.

The following determinations apply to continued stay reviews:

- **Approval:** If medical necessity is met, the clinical reviewer will authorize the continued stay.
- **Pending:** If the clinical reviewer determines that additional information is needed to complete the review, the division will contact the provider and request additional medical record information. The provider must submit the requested information by fax/mail within two (2) business days of the request for additional information.
 - If additional information is received within two (2) business days of the request and medical necessity is met, the initial review will be completed and the provider notified by fax/telephone within two (2) business days from receipt of additional information.

- If additional information is not received from the provider within two (2) business days of the request, a technical denial will be issued.
- **Deferral:** If medical necessity is not met, the case will be deferred to the division's physician consultant.
 - Within three (3) business days of deferral or receipt of additional information, the reviewing physician will determine whether the continued stay meets criteria for approval.
 - The division will notify the provider by fax/mail of the review determination within two (2) business days of the determination.
- **Partial Approval:** The Division will issue a partial approval determination when only a portion of a stay meets Medicaid medical necessity criteria.
- **Denial:** The Division will issue a denial if the request for authorization does not meet the Medicaid medical necessity criteria for the services requested.

DETERMINATIONS

Upon completion of a review, one (1) of the following determinations will be applied and notification will be made as outlined in **Notification Process** of this section:

1) **Authorization:**

An authorization determination indicates that utilization review resulted in approval for Medicaid services.

2) **Partial Approval:**

Partial approval is considered to be an adverse payment determination indicating that only a portion of a stay is authorized as medically necessary.

3) **Denial:**

The request for authorization does not meet the appropriate Medicaid medical necessity criteria for the services requested. Authorization is denied.

4) Technical Denial:

Authorization was not administered on medical necessity criteria as a result of provider non-compliance with Medicaid protocol (i.e., timeframes, incomplete documentation).

NOTIFICATION PROCESS

The division recognizes the importance of prompt notification to all relevant parties with regard to authorizations and denials. "Relevant parties" is defined as recipients, parents or legal guardians of recipients and requesting providers.

The division will implement a two-step notification process, providing both informal and formal notification.

Informal Notification

Informal notification of the determination will be made by telephone/fax/e-mail to the provider within two (2) business days of receipt of the review request. Notification will include recipient's name, determination, and applicable dates of service.

Formal Notification

Formal notification will be made by providing all relevant parties with a written determination sent by US mail. Notifications will be mailed within two (2) business days of the final determination.

- Determinations will be faxed or mailed by regular US mail

Notifications for technical denials will include:

- Dates of service that are denied a payment recommendation due to provider Medicaid protocol non-compliance
- An explanation of the right of the recipient (or legal guardian) to request an Appeal

Notifications for denial determinations for medically unnecessary services will include:

- Date of determination denying payment because the services in question are considered medically unnecessary according to Medicaid criteria or protocols.
- Case specific denial rationale based on the medical necessity criteria upon which the determination was made.
- Date of notice of the division's decision.
- An explanation of the right of the recipient (or legal guardian) to request an Appeal

DESK RECONSIDERATION / APPEAL PROCESS

Definition

Desk Reconsideration: A process to accommodate a facility's disagreement of a denial. A desk reconsideration allows the facility to submit information not previously submitted that might justify medical necessity of the recipient's treatment.

Appeal: A request from a recipient or his authorized representative to disagree with a denial for services and the opportunity to present his case to a reviewing authority.

Desk Reconsideration Process

The provider may request desk reconsideration by contacting the division by telephone, facsimile, or e-mail within ten (10) calendar days of the written notification. Desk reconsiderations are performed using the following process:

- a. Upon receipt of an adverse determination, the provider may request a desk reconsideration of the adverse determination.
- b. The request for desk reconsideration must be received by the division, either by telephone, facsimile, or e-mail within ten (10) calendar days of the written notification.
- c. The division will request that the provider submit any additional information disputing the basis for denial and copies of specific medical records.
- d. The division's clinical reviewer or physician will complete the desk reconsideration within three (3) months of receipt of the clinical information. Notification of all final determinations will include rationale for the determination.
- e. If the desk reconsideration review upholds the adverse determination, the option to appeal remains available for the recipient and/or parent or legal guardian of the recipient as indicated in the initial determination.
- f. The division is not responsible for payment to the provider for services provided to the recipient during desk reconsideration. If the outcome of the desk reconsideration reverses the denial, payment for services will be retroactive to the date of the disputed denial.
- g. Written notification will be forwarded to the provider, recipient, and/or parent or legal guardian of the recipient related to the outcome of the desk reconsideration.

Appeal Process

The division is not responsible for payment to the provider for services provided to the recipient during an appeal. If the outcome of the appeal reverses the denial, payment for services will be retroactive to the date of the disputed denial.

Recipients and/or parents and legal guardians of recipients may request an appeal through the North Dakota Division of Human Services. This request must be made within 30 calendar days of the initial denial determination notification by submitting a written request for an appeal to:

Appeals Supervisor
North Dakota Department of Human Services
Division 325
600 E. Boulevard Avenue
Bismarck, ND 58505-0250

Fair Hearing Process

The division will be available to participate in the Medicaid Fair Hearing process to provide testimony related to the determination under appeal and will provide copies of all documentation and correspondence related to the determination under appeal.

ADMISSION CRITERIA FOR ADULT AMBULATORY BEHAVIORAL HEALTHCARE

The division will employ the use of the following criteria to establish medical necessity determinations.

Service Components (must meet all of the following)

1. Assessment

A formal comprehensive biopsychosocial assessment, which may draw upon documented assessments made during the current episode of care, must be completed prior to or within 24 hours after admission to ABH. The assessment must address at a minimum:

- A medical assessment including nutritional needs.
- A psychiatric assessment including diagnostic impression, behavior and cognitive levels, presenting symptoms, results of a mental status exam and diagnostic impression.
- Chemical abuse and dependency assessment of the recipient and determination of alcohol or drug use of immediate family members, significant other or care givers.
- Activities of daily living including but not limited to employment or work, school, recreation or plan, and vocational pursuits.

- Educational status, strengths and weaknesses.
 - Peer relationships and social development.
 - Legal/custodial status and or involvement with justice system.
 - The role of the recipient in the family and the impact of the family on the recipient.
 - Strengths and weaknesses of the recipient including the ability to utilize treatment.
2. At least seventy percent (70%) of scheduled therapeutic program hours must consist of active treatment focused on stabilizing or reversing symptoms necessitating admission. Examples of active treatment include but are not limited to: group psychotherapy, medication evaluation, psychodrama, family therapy, expressive therapies and theme-specific (psycho-educational) therapy groups.
 3. Recipient must be seen and evaluated by a physician who is a member of the multi-disciplinary team preparing a therapeutic individualized treatment plan identifying the impairment(s) that caused the admission and should indicate the role of each member of the professional team in the treatment.
 4. Involvement of family, significant other or caregivers must be clearly addressed in the treatment process and incorporated into the written treatment plan.
 5. Discharge planning, along with a target date for discharge, must be initiated at time of admission, with ongoing efforts and progress towards the same, and documented in the medical record.
 6. Aftercare plan concerning the patient's relationship with significant others, post discharge therapy, school and/or work must be evident in the treatment plan.
 7. Treatment plan is updated weekly to reflect the recipient's progress and addresses any new problems that have been identified.
 8. Regular assessments and active interventions are completed by nurses, therapists, and physicians based upon the active treatment plan and documented in the progress notes. Documentation is to substantiate the level of service requested. Minimal expectations are daily notes need to include date, time spent, group topic, whether it is client or therapist initiated, affect, types of interventions used, patient response to therapies and other participants present, how this group for this patient is reflective in the care plans and if the objectives or goals were met. Author and credentials should also be included. Care plans need to be written in lay terms, but based on the DSM IV-R diagnosis. All disciplines that are ordered by the physicians must be included in the care plan. Orders need to be specific as to the days per week and the number of disciplines involved. Refer to Addendum D for documentation expectations. Documentation will meet all regulatory standards as described by JCAHO & Medicare.

Admission Criteria (must meet all of the following)

1. A primary DSM-IV diagnosis has been established. Neither substance nor chemical abuse nor rule-out conditions qualify under this criterion.
2. Meets LOCUS/CALOCUS criteria for admission to Ambulatory Behavioral Healthcare.
3. Less restrictive treatment settings have been considered or attempted.
4. Proper treatment of the recipient's psychiatric condition requires acute treatment services on an outpatient basis under the direction of a psychiatrist.
5. The recipient can be safely and effectively managed in an ABH setting without significant risk of harm to self / others.
6. The services can reasonably be expected to stabilize or improve the recipient's condition.
7. Discharge planning is initiated on admission.

CRITERIA FOR CONTINUED STAY REVIEWS

The following criteria will be used to authorize continued ABH stays.

Requirements 1, 2 and 3 must be met and either 4 or 5 or 6:

1. DSM-IV diagnosis, excluding chemical or substance abuse and R/O disorders.
AND
2. Active treatment is occurring which is focused on stabilizing or reversing symptoms which meet the admission criteria and which still exists.
AND
3. A lower level of care is inadequate to meet the recipient's needs with regard to either treatment or safety.
TOGETHER WITH
4. There is a reasonable likelihood of clinically significant benefit, including stabilization, and reduced probability of future need for a higher level of care, as a result of medical intervention requiring the ABH setting.
OR
5. A high likelihood of either risk to the patient's safety or clinical well being or of further significant acute deterioration in the patient's condition without continued care in the ABH setting, with lower levels of care inadequate to meet these needs.
OR
6. The appearance of new impairments meeting the admission guidelines.

Discharge Criteria (must meet 1 and 2 or 3)

1. The symptoms/behaviors that required services at this level of care have improved sufficiently to permit treatment at a lower level of care.
AND
2. A comprehensive discharge plan has been developed and is ready to be implemented.
OR
3. The recipient voluntarily withdraws from treatment or the person's parent or legal guardian removes them from the program.
4. Recipient is no longer obtaining benefit from current level of care and/or recipient's support system is not vested in treatment.

Ambulatory Behavioral HealthCare Prior Authorization/Continued Stay

Recipient Name:

(Last) PLEASE PRINT

(First)

(Middle Initial)

Recipient Mailing Address:

(Parent/Guardian if minor child)

Medicaid #:

DOB:

Facility

Psychiatrist

Attention:

Your FAX #

Phone

Mailing Address:

Dx. (Axis 1-5): I.

III.

II.

IV.

GAF

Locus/Calocus (Please complete Level of Care Chart and attach with your request)

Reason for partial/or need for additional partial days and treatment plan:

RECIPIENT CURRENT STATUS:

Date of discharge from inpatient care

Number of days hospitalized

List No. of days already attended

and, additional days requested

Partial Start Date

No. of days per wk attending

Estimated LOS

MEDICAL SERVICES USE ONLY:

APPROVED

No. of days

Beginning

LEVEL: A B C

FEE:

DENIED

Reason for Denial:

SIGNATURE:

DATE:

An approval concerns only the medical necessity of these services and does not guarantee payment. Reimbursement for any service is contingent upon the eligibility of the patient at the time services are provided; any applicable third parties must be billed prior to billing Medicaid. The recipient may be responsible for any recipient liability before payment is made by this department. The approved days are inclusive of all other payers. Providers are responsible for maintaining current Medicaid enrollment. Failure to do so will result in non-payment of services. Eligibility for dates of service may be verified by calling 1-800-428-4140 or 701-328-2891.

**NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
Medical Services Division**

**AMBULATORY BEHAVIORAL HEALTHCARE PRIOR AUTHORIZATION FORM
PART II**

Recipient Name: _____

Facility Name: _____

LOCUS/CALOCUS

LEVEL OF CARE	SCORE	COMMENTS
1. Risk of Harm		
2. Functional Status		
3. Comorbidity		
4(a) Recovery Environment Stress		
4(b) Recovery Environment Support		
5. Treatment Recovery History		
6. Attitude and Engagement		
7. Composite Rating _____ Level _____		

MEDICAL SERVICES USE ONLY:

COMMENTS:

North Dakota Department Of Human Services

Medical Services
600 E. Boulevard Ave Dept 325
Bismarck ND 58505
(701) 328-2321

PARTIAL APPROVAL / DENIAL FOR AMBULATORY BEHAVIORAL HEALTHCARE

Date:

To:

RE:

MA/ID#:

DOB:

Admission Level:

Effective Date:

End Date:

After review of the information submitted, it has been determined that the individual above does require ambulatory behavioral healthcare services only for the period authorized above. The basis of this decision is as follows:

If the receiving facility disagrees with this decision, a desk reconsideration may be requested of NDMA within ten (10) days of the date of this notice. The reconsideration may be requested by telephone at (701) 328-4027 or fax (701) 328-1544.

If a request for desk reconsideration is not made, submission of a request for appeal by the individual or his or her legal representative may be made to:

Appeals Supervisor
North Dakota Department of Human Services
600 East Boulevard Ave – Dept 325
Bismarck ND 58505-0261

If the individual or his or her legal representative disagree with this decision and desk consideration was not requested, the written appeal request must be forwarded to the above address within thirty (30) days of the date of this notice.

The individual or his or her legal representative may represent himself or herself at the appeal hearing or may use legal counsel, relatives, friend or other spokesperson.

If you have any questions regarding this letter, contact NDMA at (701) 328-4027.

INPATIENT

Definition: Hospital based 24 hour care delivered by a multidisciplinary team under the direction of a physician for mentally ill or chemically dependent adult, adolescent, and children who meet the criteria as defined by the DSM 1V. Adolescents and children also require CON other than emergency situations.

It should be understood that these clients are at a severity to be in imminent danger of harming self or others as described in the North Dakota Century Code.

There may be special circumstances in which individuals may require hospitalization for specific procedures i.e.; initial ECT (electro-convulsant therapy).

Medical reviews will be done on an ongoing basis by North Dakota Health Care Review, retrospectively. Denials of requested days by NDHCR that are contested by the provider are returned to the Medical Services Division for review.

National guidelines for acceptable lengths of stay will be utilized as a benchmark.

Per diem rate: The department will pay a rate based on historical charges, which will not exceed \$450.00 per day. This rate includes lab and medication services.

Revenue Codes: 110-219

Limit: 21 days per occurrence not to exceed 45 days per calendar year – As per North Dakota State Plan TN 03-012B Attachment 3.1-B – “The North Dakota Medicaid program will limit the number of inpatient psychiatric days to no more than 21 days for each inpatient psychiatric stay in a distinct part psychiatric unit of a general hospital and to no more than 45 days per calendar year. This limit does not apply to individuals for which the Medicaid program is obligated to pay for all diagnostic and treatment because they are eligible for the EPSDT program.”

AMBULATORY BEHAVIORAL HEALTH CARE PROGRAMS

DEFINITION: There are various terminology's used in the general public for this classification. Some of them, but not all are PHP, partial hospitalization, level II services, moderate intensity, psychiatric partial and CD partial. This specifically excludes inpatient and adult residential services. A general description is services rendered to mentally ill or chemically dependent clients in a hospital based or psychiatric hospital program, that consists of a multidisciplinary team (3 or more disciplines directed by a physician) that deliver multiple modalities of treatment to fit individual clients. There are multiple options that are discussed below. **The services do require prior authorization through the Medicaid Department.**

* **CLARIFICATION:** Per Diem rate indicates, as is industry standard that family, group, individual, and marital therapy is included in the rate. The per diem rate includes lab and medication services.

ACTIVE TREATMENT PROGRAM HOURS:

- Level A:**
- 1) 4-11 hours per day - 3 to 7 days per week
 - 2) 3 or more licensed professionals (disciplines) treating under the supervision of a psychiatrist.
 - 3) Fee per day:
Adults - 18 and up - \$215
Adolescents - 12 to 18 - \$255
Children - 0 to 11 - \$275
 - 4) Limit of 30 days per calendar year; 21 days per occurrence
- Level B:**
- 1) 3 hours per day 2-7 days per week
 - 2) 3 or more licensed professionals (disciplines) treating under the supervision of a psychiatrist.
 - 3) Fee per day:
Adults - 18 and up - \$150
Adolescents - 12 to 18 - \$185
Children - 0 to 11 - \$220
 - 4) Limit of 15 days per calendar year.
 - Once a level of care is changed; a new occurrence can begin.

The only acceptable Revenue code is 912 for any level of ambulatory health care, MI, CD, or Dual.

The same Revenue Codes apply for any Chemical Dependency treatment provided in the Ambulatory Health Care setting.

Chemical Dependency- Hospital Based

Definition: Other chemical dependency services rendered. These services are only to be billed on a UB 92. Current terminology's that are equated to these services are low intensity, Level I, Aftercare, and Intensive Outpatient Programming (IOP). This category is defined to assist providers in capturing services they are already providing in reference to Chemical Dependency. The client must have a primary diagnosis of CD with at least 1 to 3 disciplines involved. This is not an inpatient service. **It requires prior authorization through the Medicaid Department.** Level C can be used as a method to avoid more intensive levels of service. The number of disciplines remains one to three under the supervision of a MD. The requirement remains the same for the weekly contact (face to face) with the physician and for care conferencing or team meetings. Documentation guidelines are the same for Level A, B, and C.

LEVEL C:

Requirements: 1 to 3 hours up to 3 days per week for a maximum of 3 hours per week. (A week is considered Sunday through Saturday.) Examples: 1 hour per day for 3 days, 3 hours in one day per week, or 2 hours one day and 1 hour another day.

Limits: 20 days per calendar year

Disciplines: 1 to 3 under the supervision of a psychiatrist

Fee: Adults (over age 21) -\$10.00 per 15 minute increments.
Adolescents (under age 21) -\$11.00 per 15 minute increments.

The only acceptable Revenue code to use is 912.

Appendix D – Documentation Expectations

Documentation Expectations

Link to BHC Clinical/Case Record Review Tool for Open and Closed Records for Behavioral Health Care

http://jcsearch.jcaho.org/cgi-bin/MsmFind.exe?QUERY_ENCODING=UTF-8&CFGNAME=MssFind.cfg&QUERY=bhc+clinical%2Fcase+record+review+tool&ANDON=Y&NO_DL=X

Written instructions on how to find:

Go to www.jcaho.org

Click on the SEARCH feature

Enter in **BHC Clinical/Case Record Review Tool**

Press enter

Scroll down to Hospital Surveyor Medical Record review Tool for OP

Part I = Adults

Part II = Addendum with requirements for Children & Adolescents